Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

<u>Emailed</u> Questions and Answers Regarding the New and Modified Service Definitions

April 3, 2006

#	Service Definition Component	Question	Response	Notes
1	Community Support	Community Support is limited to certain number of hours in some instances (2hrs in Residential) and 28 hours in a week, and by authorization of a specific number of CS hours. If more hours are necessary, ie: in a crisis, how is that accounted for?	The authorization of Community Support is determined by the medical necessity of the services related to the consumer's presentation. If that presentation changes, then a request for additional services should be made to Value Options with additional information to support the medically necessary need for authorization of hours of service or new services. See also Enhanced Services Implementation Update #4 for information about authorizations during the transitional period. http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/updates/dmadmh2-21-06update4.pdf	
2	Community Support	How does billing of Community Support work when CS is being provided by different workers at the same time (ie: the QP is coordinating aspects of the PCP, and the field worker is providing skill building to the consumer at the same time)?	Community Support is a service that is authorized for a number of hours over a period of time. The determination of the frequency and duration of the authorization should take the service provided into account in determining the number of hours authorized. As this is not a provider specific definition, but rather a service specific definition. Various Community Support activities may occur at the same time and be billed within the limits of the authorization.	
3	Community Support	Will transportation be considered in the 60% requirement to be outside of the agency? What if there is a PCP meeting in the agency (instead of holding it in an outside agency) can that count in the 60% "outside the agency's facility"?	The requirement that 60% of the service be provide "outside the agency's facility" is an aggregate number and reflects the fact that most of the services provided should be directed directly to the consumer in community settings in support of the consumer developing community skills. There are periods when the % of services may be skewed one direction or the other, but it is an	

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			annual aggregate number that will be reviewed.	
4	Community Support	Will Community Support be different than CBS that has been in place? Consumers are concerned they will not have the intensity of service they have been provided in the past.	Community Support is a more intensive service that is focused on skill building in specific areas identified as goals of each consumer and family in the PCP. After the transitional period, authorization of the service may be for a lesser amount of time than had been authorized in the past, but the focus of the service on specific skill building will become apparent. The achievement of these specific goals will be the intent of CS as consumers develop the skill to function independently in the community as much as possible.	
5	Community Support	Please clarify the initial 30 day authorization for Qualified Professional and Diagnostic Assessment under Medicaid.	For Medicaid-eligible consumers, the initial authorization of Community Support is to quickly provide support for consumers while additional needs are assessed. The amount of Qualified Professional service available must be within the limitations of the definition or additional authorization must be sought. However, if a consumer is using a maximum of Qualified Professional in the first 30 days while the Diagnostic Assessment is being completed, it may be appropriate to seek a higher level of intervention beyond Qualified Professional. Documentation should indicate the services provided for the consumer based on indicated need as determined by the provider. These Qualified Professional services paid during the period will be subject to post payment review to assure the appropriateness of the service provision. Reauthorization of Qualified Professional must occur at least every 90 days.	
6	Diagnostic Assessment	Please clarify when a DA needs to be completed. Must you have a DA at the time the PCP is developed?	A Diagnostic Assessment must be completed for all new Medicaid consumers if they will access enhanced services. For current consumers, a Diagnostic Assessment may be done if there is a need to clarify the diagnosis	

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			or the consumer is not making progress in the current treatment plan. The intent is to be sure that the consumer has had an accurate assessment of their condition in order to properly address treatments. PCPs are due during the birthday month of the consumer. If a Diagnostic Assessment is needed, that assessment is due at the time of the PCP.	
7	Diagnostic Assessment	Can the persons who provide the DA be contracted as needed to provide that service?	For Medicaid, in order to provide the DA, the agency must be endorsed by the LME and enrolled with the Division of Medical Assistance. The agency may have arrangements with providers to provide components of that assessment, but the agency must bill and be responsible for the quality of the service. The DA must be done by two QPs described in the definition, and who each see the consumer in a face to face meeting to complete the assessment.	
8	Diagnostic Assessment	Can a Diagnostic Assessment be provided in Inpatient hospital or ADATC settings?	The comprehensive assessment conducted while a consumer is in a higher level of care (e.g., within Inpatient and ADATC settings) will replace the need for a Diagnostic Assessment. In some instances, additional assessment information may be needed to clarify diagnoses or treatment needs, in which cases the 90801 assessments may be conducted. (inpatient), and this information may be used in the development of the PCP, thereby not requiring an additional DA to be completed after discharge. The information gathered in the comprehensive and 90801 assessments may be used in the development of the PCP; thus not requiring a Diagnostic Assessment to be completed after discharge from the higher level of care settings.	
9	SA and Detox Services	Can licensed professionals (e.g., LCSW, Licensed psychologists, LPC) provide the new enhanced substance abuse services?	Yes, licensed professionals are considered qualified professionals. Each of the Substance Abuse enhanced services includes the requirement for Qualified Professionals with experience in substance abuse	

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			services to meet the staffing requirements.	
10	SA and Detox Services	Does a Licensed Professional have to be certified or licensed by the NC Substance Abuse Practice Board in order to provide the enhanced SA services?	No. Check with the NC Substance Abuse Practice Board for specific questions regarding certification and licensure requirements to provide substance abuse services in NC.	
11	SA and Detox Services	Will the licensed professional be required to receive clinical supervision by an LCAS or CCS if indicated in the service definition?	The LCAS or CCS will provide supervision of the clinical aspects of the program to the staff. Licensing boards may still require additional supervision for staff who are licensed/certified professionals providing substance abuse services.	